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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ROBERT WILLIAM ANDERSON, JR.** **8861 Morninglight circle** **Riverside, CA 92508** **Registered Nurse License No. 566338** **Public Health Nurse Certification No. 64857** Respondent.	Case No. 2010-277 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about April 20, 2000, the Board of Registered Nursing issued Registered Nurse License Number 566338 to Robert William Anderson, Jr. (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2009, unless renewed.

3. On or about March 20, 2002, the Board of Registered Nursing issued Public Health Nurse Certification Number 64857 to Robert William Anderson, Jr. (Respondent). The Public

Health Nurse Certification was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2009, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

7. Section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it. . . ."

8. Section 2762 states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with

Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . . .

"(c) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. Section 4022 defines "Dangerous Drugs" as any drug that is unsafe for self-medication and which by federal or state law can be lawfully dispensed only on prescription.

10. Section 4060 states, in pertinent part:

"No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, or veterinarian, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, or a physician assistant pursuant to Section 3502.1."

11. California Code of Regulations, title 16, section 1444, states:

"A[n] . . . act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such . . . acts shall include but not be limited to the following:

. . . .

"(c) Theft, dishonesty, fraud, or deceit. . . ."

12. Health & Safety Code section 11173(a), states that no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge.

13. Health & Safety Code section 11173(b), states that no person shall make a false statement in any prescription, order, report, or record, required by this division.

14. Health and Safety Code section 11350 states, in pertinent part that except as otherwise provided in this division, every person who possesses any controlled substance which

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is a narcotic drug, unless upon the written prescription of a physician licensed to practice in this state, shall be punished by imprisonment in the state prison.

15. California Code of Regulations, title 16, section 1444, states:

"A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

. . . .

"(c) Theft, dishonesty, fraud, or deceit.

16. Business and Professions Code section 125.3 states that:

"(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceedings, the administrative law judge may direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

17. DEFINITIONS

A. "Morphine Sulfate" (alkaloid of opium) is a dangerous drug as defined in section 4022 of the Code. It is classified as a Schedule II controlled substance as listed in Health and Safety Code section 11055(b)(1)(m).

B. "Dilaudid" is a trade name for hydromorphone hydrochloride. It is a Schedule II controlled substance as defined by Health and Safety Code section 11055, subdivision (d) and a dangerous drug pursuant to Business and Professions Code section 4022.

C. "Omnicell SureMed" is a computerized automated single-dose medication distribution system that operates similarly to an automated teller machine at a bank. Medications can be withdrawn from the Omnicell machine only by an authorized staff person using his or her own personalized access code. The Omnicell machine makes a record of the medication, dosage, date and time of withdrawal, user identification, and patient for whom it was withdrawn.

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18. Respondent began his employment as a registered nurse at Community Hospital of San Bernardino, San Bernardino, California in March or April, 2006. Respondent resigned in lieu of termination on February 15, 2007.

19. Respondent is subject to disciplinary action under section 2761, subdivisions (a) and (d), defined by section 2762, subdivision (e), and California Code of Regulations, title 16, section 1444, subdivision (c), in that, while on duty as a registered nurse at Community Hospital of San Bernardino, San Bernardino, California, in the Emergency Department (ED), Respondent falsified, or made grossly incorrect, or grossly inconsistent entries, in hospital and patient records as described herein:

Patient #A

a). On or about February 6, 2007, at 7: 02 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system in the Emergency Department (all removal was from the ED unless otherwise indicated) as reflected in the Omnicell report. The nursing notes reflect that at 7:20 p.m., 4 mg of Morphine was administered to this patient. There was no order for Morphine for this patient by any physician. On February 7, 2007 at 3:03 a.m., Respondent documented that he wasted 4 mg of Morphine. He failed to account for the remaining 2 mg of Morphine in any hospital record.

Patient #B

b). On or about January 22, 2007, at 11: 10 p.m., Respondent withdrew a 10 mg syringe of Dilaudid for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. There was no order for Dilaudid for this patient by any physician. Respondent did not document administration of Dilaudid to the patient and on January 23, 2007 at 12:55 a.m., Respondent documented that he wasted the 2 mg of Dilaudid.

Patient #C

c). On or about February 3, 2007, at 9:59 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. There was no order for Morphine for this patient by any

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physician. Respondent did not document administration of Morphine to the patient nor did he otherwise account for the 10 mg syringe of Morphine in any hospital record.

Patient #D

d). On or about January 22, 2007, at 8:31 p.m., Respondent withdrew a 2 mg syringe of Dilaudid for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. The ED record reflects that at 8:20 p.m., 0.5 mg of Dilaudid was administered to this patient. Physician's orders for this patient were for Morphine, not Dilaudid. Moreover, Respondent failed to account for the remaining 1.5 mg of Dilaudid in any hospital record.

Patient #E

e). On or about January 1, 2007, at 11: 27 p.m., Respondent withdrew a 10 mg syringe of Morphine for this 4-year-old patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. There was no order for Morphine for this patient by any physician. Moreover, the patient was transferred to LLUMC on December 31, 2006. Respondent did not document administration of Morphine to the patient and on January 2, 2007 at 4:38 a.m., Respondent documented that he wasted 6 mg of Morphine.

Patient #F

f). On or about November 28, 2006, at 7: 46 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. On November 29 2006, at 1:54 a.m., Respondent recorded in the nursing notes that at 7:50 p.m., 2 mg of Morphine was administered to this patient. On November 29 2006, at 12:48 a.m., Respondent documented that he wasted 6 mg of Morphine. He failed to account for the remaining 2 mg of Morphine in any hospital record.

Patient #G

g). On or about January 22, 2007, at 7: 47 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. The ED record reflects that at 7:45 p.m., 2 mg of Morphine was administered to this patient. The handwriting in this entry is different from all other entries in the

record. The ED physician signed out at 6:00 p.m. and the admission orders for this patient did not include an order for Morphine by this or any other physician. Respondent failed to account for the remaining 8 mg of Morphine in any hospital record.

Patient #H

h). On or about January 9, 2007, at 7: 31 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. At 11:15 p.m., Respondent documented a physician's order for 1-2 mg of morphine PRN for pain. There was no order for Morphine recorded in the ED physician's orders for this patient by any physician prior to Respondent's 11:15 entry. At 12:07 a.m., Respondent documented in the nursing notes that he administered 2 mg of Morphine to the patient at 11:45 p.m. and at 11:46 p.m., Respondent documented that he wasted 8 mg of Morphine.

Patient #I

i). On or about January 5, 2007, at 1: 02 a.m., Respondent withdrew a 2 mg syringe of Dilaudid for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. Physician's orders for this patient were for Morphine, not Dilaudid. At 2:56, a.m., he documented that he wasted 2 mg of Dilaudid. At 1:46 a.m., Respondent withdrew a 10 mg syringe of Morphine for this patient. At 4:02 a.m., Respondent documented in the nursing notes that he administered 2 mg of Morphine to the patient at 1:40 a.m. and at 6:15 a.m., Respondent documented that he wasted 8 mg of Morphine.

Patient #J

j). On or about August 10, 2006, at 10: 55 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the CCU department Omnicell system as reflected in the Omnicell report. At 11:00, p.m., he documented in the ED record and nursing notes that he administered 2 mg of Morphine to the patient. At 12:44 a.m., Respondent withdrew another 10 mg syringe of Morphine from the CCU department Omnicell system for this patient. At 12:45 a.m., Respondent documented in the ED record that he

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administered 2 mg of Morphine to the patient. At 5:34 a.m., Respondent documented that he wasted the 2 syringes containing 8 mg each of Morphine.

Patient # K

k. On or about January 5, 2007, at 9:51 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. The physician's order was for 2 mg Morphine was not written into in the ED record until 11:05 p.m. At 12:13 a.m., he documented in the nursing notes that he administered 2 mg of Morphine to the patient. At 12:00 a.m., Respondent withdrew a 2 mg syringe of Dilaudid from the Omnicell system for this patient. At 11:00 p.m., he charted a physician's order for 2 mg Dilaudid IV every 4 hours pm. There was no documentation of this order on the ED Admission Orders which was recorded at 11:10 p.m. On January 6, 2007, at 2:32 a.m., Respondent documented in the nursing notes that at 12:30 a.m., he administered 2 mg of Dilaudid and 25 mg phenergan to the patient. At 12:33 a.m., Respondent documented that he wasted 8 mg of Morphine.

Patient # L

l. On or about June 6, 2006, at 8:30 a.m., Respondent withdrew a 10 mg syringe of Morphine (first syringe) for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report and charted in the Medication Administration Record (MAR) that 4 mg of Morphine was administered to the patient. At 8:52 a.m., he documented that he wasted 6 mg of Morphine. At 1:20 p.m., Respondent withdrew another 10 mg syringe of Morphine (second syringe) for this patient and documented on the MAR that he administered 4 mg of Morphine to the patient. At 3:20 p.m., Respondent documented on the MAR that he administered 2 mg of Morphine to the patient. At 6:02 p.m., Respondent withdrew another 10 mg syringe of Morphine (third syringe) for this patient and documented at 6:00 p.m. that he administered 4 mg of Morphine to the patient. At 6:11 p.m., Respondent documented that he wasted 6 mg of Morphine.

Respondent failed to account for 4 mg of Morphine from the second syringe, or in the alternative, failed to account for 6 mg of Morphine unless he reused the second syringe on the

patient to administer the 2 mg dose given at 3:20. Respondent further failed to chart the administration of Morphine to this patient on any nursing notes.

Patient # M

m. On or about February 28, 2006, at 9:27 p.m., Respondent withdrew a 10 mg syringe of Morphine (first syringe) for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. At 9:00 p.m., he charted on the MAR that he administered 4 mg of Morphine to the patient. On March 1, 2006, at 2:57 a.m., Respondent withdrew another 10 mg syringe of Morphine (second syringe) for this patient. At 11:00 p.m., Respondent charted that he administered 2 mg of Morphine to the patient, at 11:00 p.m., on February 28, 2006. At 5:15 a.m., Respondent withdrew another 10 mg syringe of Morphine (third syringe) and charted on the MAR that he administered 4 mg of Morphine to the patient at 5:15 a.m. At 5:39 a.m., Respondent documented that he wasted 6 mg of Morphine. At 5:41 a.m., Respondent documented that he wasted 2 syringes containing 6 mg each of Morphine. Respondent failed to record any of the administration of Morphine to this patient in the nursing notes.

Patient # N

n. On or about April 20, 2006, at 7:46 a.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. At 7:40 a.m., he charted on MAR that he administered 3 mg of Morphine to the patient. Physician's orders were for 3 mg Morphine IV every 2 hours PRN. The patient had just received 3 mg of Morphine at 6:30 a.m. At 9:40 a.m., Respondent charted on the MAR that he administered 3 mg of Morphine to the patient. At 11:50 a.m., Respondent documented on the MAR that he administered 3 mg of Morphine to the patient. No additional syringes were withdrawn by any hospital personnel for the last two administrations charted by Respondent. Respondent did not chart any nursing notes during his shift regarding Morphine or pain for this patient on April 2, 2006.

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Patient # O

o. On or about January 2, 2007, at 10:45 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. There was no physician's order for Morphine for this patient by any physician. Respondent did not chart the administration of this drug to the patient. At 10:30 p.m., Respondent documented that he wasted the syringe containing 10 mg of Morphine rather than returning the unused syringe.

Patient # P

p. On or about May 27, 2006, at 7:51 a.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. At 7:30 a.m., he documented on the MAR and nursing notes that he administered 2 mg of Morphine to the patient. Respondent charted that he also administered 2 mg of Morphine to the patient at 11:00 a.m., 2:00 p.m., 4:00 p.m., and 6:00 p.m. Physician's orders were for 2 mg Morphine IV every 4 hours PRN and there were no further orders in any hospital record for additional doses of Morphine or change in frequency of dosage. While Respondent charted the times that he administered the aforementioned doses of Morphine, he failed to cross off the times indicating that the doses were in fact given. Moreover, Respondent did not chart the doses at 11:00 a.m., 2:00 p.m., 4:00 p.m. and 6:00 p.m. in the nursing notes.

Patient # Q

q. On or about January 1, 2007, at 8:02 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. At 8:40 p.m., he documented in the ED record that he administered 2 mg of Morphine to the patient. At 10:43 p.m., he documented this administration in his nursing notes. At 3:08 a.m., on January 2, 2007, Respondent documented that he wasted 6 mg of Morphine. Respondent failed to account for the remaining 2 mg of Morphine in any hospital record.

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Patient # R

r. On or about January 1, 2007, at 11:13 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. At 8:45 p.m., he documented in the admission orders a physician's order for 2 mg of Morphine IV every 2 hours PRN for the patient. There was no physician's order for Morphine on the ED record, moreover, admission notes indicates that the patient had not been received on the ED floor until sometime between 11:00 p.m. and 11:30 p.m. Respondent failed to document administration of Morphine to the patient in any hospital record. At 3:08 a.m., Respondent documented that he wasted 6 mg of Morphine. Respondent failed to account for the remaining 4 mg of Morphine in any hospital record.

Patient # S

s. On or about October 3, 2006, at 9:07 a.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. At 9:05 a.m., he documented in the ED record that he administered 2 mg of Morphine to the patient. He further documented this dose in the nursing notes at 9:57 a.m. At 7:01 p.m., Respondent documented that he wasted 6 mg each of Morphine. Respondent failed to account for the remaining 2 mg of Morphine in any hospital record.

Patient # T

t. On or about January 2, 2007, at 8:29 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. At 8:30 p.m., Respondent charted in the ED record that he administered 2 mg of Morphine to the patient. He further documented this dose in the nursing notes at 9:25 p.m. Respondent failed to account for the remaining 2 mg of Morphine in any hospital record.

Patient # U

u. On or about November 8, 2006, at 11:42 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. Respondent charted in the ED record that at 11:48 p.m., 2 mg of

Morphine was administered to this patient. At 1:32 a.m., he further charted this dose in the nursing notes. At 12:49 a.m., Respondent documented that he charted 6 mg of Morphine. Respondent failed to account for the remaining 2 mg of Morphine in any hospital record.

Patient # V

v. On or about December 4, 2006, at 5:31 a.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. At 5:30 a.m., Respondent recorded in the ED record and nursing notes that 2 mg of Morphine was administered to this patient. At 7:08 a.m., Respondent documented that he wasted 6 mg of Morphine. He failed to account for the remaining 2 mg of Morphine in any hospital record.

Patient W

w. On or about November 28, 2006, at 7:22 p.m., Respondent withdrew a 10 mg syringe of Morphine for this 15-year-old patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. There was no order for Morphine for this patient by any physician. In fact, no medications were ordered for this patient, who was seen for mild abdominal pain, nausea, and vomiting. Respondent did not document administration of Morphine to the patient and at 7:45, Respondent documented that he wasted the syringe rather than returning the unused syringe.

Patient # X

x. On or about December 25, 2006, at 5:33 p.m., Respondent withdrew a 10 mg syringe of Morphine for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. At 5:30 p.m., Respondent charted that 4 mg of Morphine was administered to the patient. He also charted this dose in the nursing notes at 5:46 p.m. At 6:59 p.m., Respondent documented that he wasted 4 mg of Morphine. Respondent failed to account for the remaining 2 mg of Morphine in any hospital record. Additionally, the physician's order on the ED record did not state the time interval as required and it appears to be in different handwriting from other orders.

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Patient # Y

y. On or about December 11, 2006, at 6:00 p.m., a 4 mg syringe of Morphine was withdrawn by another RN, (S.O.) by entering S.O.'s personalized access code into the Omnicell system as reflected in the Omnicell report. S.O. charted on the ED record and nursing notes that at 6:00 p.m., 2 mg of Morphine was administered to this patient. At 7:03 p.m., S.O. charted in the nursing notes that the "patient's pain level is 2/10, able to tolerate pain at this level." At 7:11 p.m., the remaining 2 mg of Morphine was properly wasted.

At 7:21 p.m., on December 11, 2006, Respondent withdrew a 10 mg syringe of Morphine (first syringe) for this patient by entering his personalized access code into the Omnicell system as reflected in the Omnicell report. At 8:10 p.m., Respondent charted on the ED record that he administered 2 mg of Morphine to the patient. At 12:27 a.m., he charted this dose in the nursing notes. Also at 8:10 p.m., an order for 2 mg Morphine with no reference to route or time interval was documented on the ED record and appears to be in different handwriting from all of the other orders. At 8:19 p.m., Respondent withdrew a 10 mg syringe of Morphine (second syringe) for this patient from the Omnicell system. At 1:51 a.m., Respondent documented that he wasted a 10 mg syringe and 6 mg syringe of Morphine. Respondent failed to account for the remaining 2 mg of Morphine from the first withdrawn syringe.

Patient AA

On February 6, 2007, Respondent withdrew 10 mg of Morphine for Patient AA, at 11:22 p.m. At 11:20, JW documented that 2 mg of Morphine was administered to the patient. There were no other withdrawals of Morphine for this patient on February 6, 2007. Approximately 3 hours later, at 3:05 a.m., on February 7, 2007, Respondent documented that he wasted 8 mg of Morphine.

Patient BB

On February 4, 2007, Respondent withdrew 2 mg of Dilaudid for Patient BB, at 9:24 p.m., and charted that he administered 5 mg to the patient at 9:25 p.m. in the nursing notes. He also charted this dose on the ED record at 9:25 p.m. On February 5, 2007, at 6:06 a.m. (approximately

8 1/2 hours later) another RN, JT, wasted 1.5 mg of Dilaudid which was witnessed by Respondent.

Patient CC

On January 23, 2007, Respondent withdrew 2 mg of Dilaudid for Patient CC, at 7:22 p.m. and charted that he administered 1 mg of Dilaudid to the patient at 7:10 p.m. Approximately 5 1/2 hours later, at 12:57 a.m., on January 24, 2007, Respondent documented that he wasted 1 mg of Dilaudid.

Patient DD

On January 23, 2007, at 6:37 p.m., Respondent withdrew 2 mg of Dilaudid for patient DD. At 7:09 p.m., he charted that he administered 1 mg of Dilaudid to the patient at 6:35. Approximately 6 hours later, at 12:59 a.m., on January 24, 2007, Respondent documented that he wasted 1 mg of Dilaudid.

Patient EE

On January 23, 2007, at 10:05 p.m., Respondent withdrew 10 mg of Morphine for Patient EE. At 11:58, he charted that he administered 2 mg of Morphine to the patient at 10:00 a.m. Approximately 3 hours later, at 12:57 a.m., on January 24, 2007, Respondent documented that he wasted 8 mg of Morphine

Patient FF

On January 20, 2007, at 11:23 p.m., Respondent withdrew 10 mg of Morphine for Patient FF. At 11:31 p.m., AER, another RN, documented in the nursing notes that 6 mg of Morphine was administered to the patient at 11:30 p.m. At 1:00 a.m., AER wasted 2 syringes, one containing 6 mg of Morphine and another containing 4 mg of Morphine with Respondent witnessing each wastage.

At 1:21 a.m., Respondent withdrew 10 mg of Morphine for Patient FF. The ED record reflects that 4 mg of Morphine was administered to the patient. Approximately 5 1/2 hours later, at 7:01 a.m., Respondent documented that he wasted 4 mg of Morphine. Respondent failed to account for the remaining 2 mg of Morphine in any hospital record.

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Patient GG

On January 19, 2007, at 7:05 p.m., Respondent withdrew 10 mg of Morphine for Patient GG. At 7:05 p.m., Respondent documented in the nursing notes that he administered 4 mg of Morphine to the patient. Approximately 11 hours later, at 6:13 a.m., on January 20, 2007, JL, another RN, documented that JL wasted 6 mg of Morphine which was witnessed by Respondent.

Patient HH

On January 19, 2007, at 8:56 p.m., Respondent withdrew 10 mg of Morphine for Patient HH. At 1:42 a.m., he documented that he administered 4 mg of Morphine to the patient at 9:00 p.m. Approximately 9 hours after the Omnicell withdrawal, Respondent documented that he wasted 6 mg of Morphine.

Patient II

On January 16, 2007, at 4:15 a.m., Respondent withdrew a 10 mg syringe of Morphine for Patient II and charted at that he administered 2 mg of Morphine to the patient. At 6:52 a.m., he documented that he wasted 8 mg of Morphine.

Patient JJ

On January 15, 2007, at 10:57 p.m., Respondent withdrew a 10 mg syringe of Morphine for Patient JJ and charted that he administered 4 mg of Morphine to the patient at 11:00 p.m. Approximately 5 hours later, AMB documented that AMB wasted 6 mg of Morphine which was witnessed by Respondent.

Patient KK

On January 10, 2007, at 2:57 a.m., Respondent withdrew a 10 mg syringe of Morphine for Patient KK, and charted that he administered 2 mg of Morphine to the patient at 2:55 a.m. At 5:18 a.m., he documented that he wasted 8 mg of Morphine.

Patient LL

On January 10, 2007, at 2:46 a.m., Respondent withdrew a 10 mg syringe of Morphine for Patient LL and charted that he gave 2 mg of Morphine to the patient at 2:45 a.m. At 5:17 a.m., he documented that he wasted 8 mg of Morphine.

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Patient MM

On January 10, 2007, at 12:43 a.m., Respondent withdrew a 10 mg syringe of Morphine for Patient MM. AER, another RN, charted that 2 mg of Morphine was administered to the patient at 12:54 a.m. Approximately 5 hours later, at 5:16 a.m., Respondent documented that he wasted 8 mg of Morphine.

Patient NN

On January 9, 2007, at 12:23 a.m. and 12:36 a.m. respectively, Respondent withdrew a total of two 4 mg syringes of Dilaudid for Patient NN. Patient NN was discharged from the hospital on January 8, 2007, at 7:40 p.m. Over 3 1/2 hours later, another RN, AR, documented that he wasted a syringe containing 2 mg of Dilaudid and a syringe containing 1.5 mg of Dilaudid which was witnessed by Respondent. Nursing notes recorded by another RN, RLR, states that "Dilaudid 0.5 mg given SNP by Rob, RN after effects of med given to PT and no allergies noted or reported. Hub of HL came loose during administration of med and most all of med leaked back out onto linen. ERMO informed and repeat doze verbally ordered. Dose repeated by Rob, RN. SIVP and site flushed for potency."

Patient OO

On January 4, 2007, at 8:43 p.m., Respondent withdrew a 10 mg syringe of Morphine for Patient OO and charted that he administered 2 mg of Morphine to the patient at 8:35 p.m. Approximately 6 hours later, at 2:54 a.m., on January 5, 2007, another RN, SO, documented that he wasted 8 mg of Morphine which Respondent witnessed.

Patient PP

On January 3, 2007, at 5:47 a.m., Respondent withdrew a 10 mg syringe of Morphine for Patient PP and charted that he administered 2 mg of Morphine to the patient at 5:45 a.m. At 6:57 a.m., he documented that he wasted 8 mg of Morphine.

Patient QQ

On January 3, 2007, at 12:49 a.m., Respondent withdrew a 10 mg syringe of Morphine for Patient QQ and charted that he administered 2 mg of Morphine to the patient at 12:50 a.m. At

2:10 a.m., another RN, SG, documented that SG wasted 8 mg of Morphine which Respondent witnessed.

Patient RR

On January 2, 2007, at 12:55 a.m., Respondent withdrew a 10 mg syringe of Morphine for Patient RR, and charted that he administered 4 mg of Morphine at 1:00 a.m. At 3:09 a.m., another RN, WP, documented that WP wasted 6 mg of Morphine which Respondent witnessed.

Patient SS

On January 2, 2007, at 11:41 p.m., Respondent withdrew a 10 mg syringe of Morphine for Patient SS and charted that he administered 4 mg of Morphine to the patient at 11:40 p.m. At 2:09 a.m., another RN, SG, documented that SG wasted 6 mg of Morphine which Respondent witnessed.

Patient TT

On December 25, 2006, at 10:49 a.m., Respondent withdrew a 10 mg syringe of Morphine for Patient TT. Another RN, MC, charted that 4 mg of Morphine was administered to the patient at 11:12 a.m. Respondent did not chart this dose. At 12:35 a.m., he documented that he wasted 6 mg of Morphine.

Patient UU

On December 17, 2006, at 10:47 p.m., Respondent withdrew a 10 mg syringe of Morphine for Patient UU and charted that he administered 2 mg of Morphine to the patient at 10:50 p.m. Approximately 5 hours later, at 4:34 a.m., another RN, AR, documented that AR wasted 8 mg of Morphine which Respondent witnessed.

Patient VV

On December 9, 2006, at 12:10 a.m., Respondent withdrew a 10 mg syringe of Morphine for Patient VV, and charted that he administered 2 mg of Morphine at 12:10 a.m. Approximately 7 hours later, at 7:15 a.m., Respondent documented that he wasted 8 mg of Morphine.

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Patient WW

On December 1, 2006, at 6:28 a.m., Respondent withdrew a 10 mg syringe of Morphine for Patient WW and charted that at 6:26 a.m. that he administered 2 mg of Morphine to the patient. At 7:17 a.m., he documented that he wasted 8 mg of Morphine.

Patient XX

On December 1, 2006, at 8:37 p.m., Respondent withdrew a 10 mg syringe of Morphine for Patient XX and charted that he administered 4 mg of Morphine to the patient at 8:40 p.m. At 9:08 p.m. another RN, TC, documented that TC wasted 6 mg of Morphine which was witnessed by Respondent.

Patient YY

On December 1, 2006, at 7:18 p.m., Respondent withdrew a 10 mg syringe of Morphine for Patient YY, and charted that he administered 4 mg of Morphine to the patient at 7:17 a.m. At 9:08 a.m., TC another RN, charted that TC wasted 6 mg of Morphine which was witnessed by Respondent.

Patient ZZ

On November 28, 2006, at 10:08 p.m., Respondent withdrew a 10 mg syringe of Morphine for Patient ZZ and charted that he gave 2 mg of Morphine to the patient at 10:15 p.m. At 12:48 a.m., he documented that he wasted 8 mg of Morphine.

Patient AAA

On November 26, 2006, at 7:21 p.m., Respondent withdrew a 10 mg syringe of Morphine for Patient AAA and charted that he administered 4 mg of Morphine to the patient. At 7:15 p.m., he documented that he wasted 6 mg of Morphine.

Patient BBB

On November 18, 2006, at 6:41 p.m., Respondent withdrew a 10 mg syringe of Morphine for Patient BBB and charted that he administered 2 mg of Morphine to the patient at 6:42 p.m. At 7:13 a.m., he documented that he wasted 8 mg of Morphine.

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Patient CCC

On November 11, 2006, at 2:32 a.m., Respondent withdrew a 10 mg syringe of Morphine for Patient CCC, and charted that he administered 2 mg of Morphine to the patient at 2:31 a.m. Approximately 3 hours later, at 5:46 a.m., he documented that he wasted 6 mg of Morphine.

Patient DDD

On October 8, 2006, at 7:21 p.m., Respondent withdrew a 10 mg syringe of Morphine for Patient DDD and charted that he gave 2 mg of Morphine to the patient at 7:30 p.m. At 9:36 p.m., he documented that he wasted 8 mg of Morphine.

Patient EEE

On October 3, 2006, at 4:38 p.m., Respondent withdrew a 10 mg syringe of Morphine for Patient EEE. Another RN, RSA, charted that RSA administered 2 mg of Morphine to the patient at 4:35 p.m. At 1:47 p.m., Respondent documented that he wasted 8 mg of Morphine which Respondent witnessed.

Patient FFF

On October 3, 2006, at 11:06 a.m., Respondent withdrew a 10 mg syringe of Morphine for Patient FFF. RSA, another RN, charted that RSA administered 2 mg of Morphine to the patient at 11:20 a.m. At 1:47 p.m., Respondent documented that he wasted 6 mg of Morphine.

SECOND CAUSE FOR DISCIPLINE

(Obtained and Possessed Controlled Substances)

20. Respondent is subject to disciplinary action pursuant to section 2761, subdivision (a), on the grounds of unprofessional conduct as defined in section 2762, subdivision (a), in that Respondent obtained controlled substances, by fraud, deceit, misrepresentation or subterfuge in violation of Health and Safety Code sections 11173, subdivisions (a) and (b), when he took the controlled substances from Community Hospital of San Bernardino, San Bernardino, California, in the Emergency Department (ED) as set forth above in paragraph 19.

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THIRD CAUSE FOR DISCIPLINE

(Possession of Controlled Substances and Dangerous Drugs)

21. Respondent is subject to disciplinary action pursuant to section 2761, subdivision (a), as defined in section 2762, subdivision (a), and 4060, on the grounds of unprofessional conduct, in violation of Health and Safety Code sections 11350 in that Respondent obtained and possessed the controlled substances without physicians' orders, as set forth above in paragraph 19.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

22. Respondent is subject to disciplinary action pursuant to section 2761 subdivision (a) in that while employed as a registered nurse by Community Hospital of San Bernardino, San Bernardino, California, he committed acts of unprofessional conduct by falsifying hospital records and diverting dangerous drugs and controlled substances for his own personal use as set forth above in paragraph 19.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

23. Respondent is subject to disciplinary action pursuant to section 2761 subdivision (a) (1) in that while employed as a registered nurse by Community Hospital of San Bernardino, San Bernardino, California, he committed acts of gross negligence and/or incompetence by his actions as set forth above in paragraph 19.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 566338, issued to Robert William Anderson, Jr.;

2. Revoking or suspending Public Health Nurse Certification Number 64857, issued to Robert William Anderson, Jr.;

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3. Ordering Robert William Anderson, Jr. to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

4. Taking such other and further action as deemed necessary and proper.

DATED: 11/24/09

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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